

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34954
STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 42 Primary Registration District No. 5134 Registrar's No. 1102

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Buchanan (mission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Twp.		c. CITY OR TOWN St. Joseph 01172	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Green Acres Nursing		d. STREET ADDRESS Green Acres Nursing Home	
3. NAME OF DECEASED Home (Type or print) Ruth		4. DATE OF DEATH OCT. 8, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Grant City, Missouri	
13a. FATHER'S NAME Martin Stull		14. NAME OF HUSBAND OR WIFE Divorced	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, up, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Soc. Welfare Records		Address St. Joseph, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to, above cause (a), stating the under- lying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE			UKN.
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION St. Joseph, Mo.		COUNTY Mo. STATE Mo.	
21. I attended the deceased from 6/14/57 to 10/8/57 and last saw her alive on 10/7/57 Death occurred at 4:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Orliss P. Pandy M.D.		22b. ADDRESS Social Welfare Board. 10th & Olive St. St. Joseph, Mo.	
22c. DATE SIGNED 10/9/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 10, 1957	
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Public Semetary		23d. LOCATION (City, town, or county) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Clark Funeral Home		25. DATE RECD. BY LOCAL REG. Oct. 14, 1957	
26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4238

P. O. Address _____

*Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.